INP
Section III

Preparation and Use of Inpatient Treatment Records

8-9. Inpatient treatment records content

ITRs must be accurate, complete, and current. The ITR must reflect the patient's current status and treatment. After discharge of a patient, the practitioner will complete the final progress note on SF 509, SF 502, and DA Form 3647 or CHCS automated cover sheet within 4 working days. If a test result is pending, 7 working days will be allowed. If the transcription of dictated reports is delayed, the practitioner will have met his or her requirements as pertains to the completion of the ITR. Each MTF will establish internal policy to satisfy the requirement of the Joint Commission on Accreditation of Healthcare Organizations for a completed ITR. Records will be completed using available findings; delayed reports will be filed in the ITR when received and, if needed, a corrected DA Form 3647 or CHCS automated cover sheet will be prepared. Records will be reviewed per this chapter and paragraph 10-3.

a. If requested by the attending physician, ITRs from previous admissions, OTRs, HRECs, and medical records for transferred patients will be provided.

b. Reports needed for the ITR will be completed promptly. (See para 8-10.) As laboratory, consultation, or other reports are completed, they will be added to the ITR along with any progress notes (SF 509) (para 8-10b) and other notes made by health-care providers.

c. When the patient is discharged, the attending physician will prepare SF 502 (para 8-10e), complete the DA Form 3647 worksheet (section IV) or CHCS automated cover sheet, and send the completed ITR through channels to the patient administration division. Copies of ITRs received with a transferred patient will be sent with the completed ITR to the patient administration division and filed in the DA Form 3444-series folder (para 8-2b(2)). OTRs and HRECs will be returned to the proper records custodian.

d. In obstetrical cases, an ITR will be prepared when the patient is hospitalized for termination of pregnancy. All prenatal care records will be filed in this ITR.

e. The disposition of a patient will not be delayed to complete a record. If a case ends in death and an autopsy is to be performed, the attending physician must send the ITR to the pathologist for use in the autopsy, along with a sufficient summary of the case, which may be informal, even oral. The pathologist will return the ITR to the attending physician as soon as possible so that it may be completed and sent to the patient administration division. (See para 8-10f.)

8-10. Medical reports

The forms and reports to be filed in an ITR depend on the nature of the case and the treatment given. All forms and reports needed for a case will be included. (Automated versions of forms, basic policies for these reports, and the recording of diagnoses are discussed in chap 3.) Specific reporting needs are described in a through f below.

a. History and physical. An admission workup will be prepared on SF 504 (Clinical Record--History--Part I), SF 505 (Clinical Record--History--Parts II and III), and SF 506 (Clinical Record--Physical Examination) within 24 hours of admission. These forms will be as pertinent and complete as needed for proper patient management. Before surgery under general anesthesia is performed, the ITR must include a complete history and a current, thorough physical examination. (The cardiopulmonary system findings will be fully recorded; terms such as "normal," "wnl," and "negative" will not be used.) These reports are not needed, however, in emergencies; for emergency surgery, the physician will report only vital signs, pertinent physical findings, and any allergies (if known). (Also see paras 8-11 and 8-17 for information on SF 504, SF 505, and SF 506.)

(1) Transfer-in cases. If an adequate history and physical arrive with a transfer-in patient, an interval progress note (SF 509) stating that there has been no change will suffice. If there are important changes, they will be clearly and fully reported. If the patient arrives without a history and physical or with inadequate ones, the needed reports will be prepared by the servicing MTF. (If this inadequacy was caused by negligence, the commander of the transferring MTF will be advised of it and corrective action will be requested.) (Also see paras 5-16b(3) and 8-11 for information on SF 509.)

(2) Readmission. When a patient is readmitted within 30 days for the same or a related condition, an interval history and physical will be written in the progress notes (SF 509). These reports will describe any pertinent changes. However, these interval reports are allowed only if a copy of the original history and physical is also sent to the attending physician.

(3) Documentation on SF 504, SF 505, and SF 506. Admission history and physical examinations will be recorded on SF 504, SF 505, and SF 506 only by staff physicians, qualifying oral and maxillofacial surgeons, residents, and certified midwives as appropriate. Podiatrists may record and perform admission histories and physical examinations on podiatry patients only on the podiatry problem on SF 504, SF 505, and SF 506. The medical history and physical examination (head, eyes, ears, lungs, heart, and so forth) must be performed and signed by a physician (doctor of medicine or doctor of osteopathy). In programs for children and adolescents, developmental age factors will be evaluated, educational needs will be considered, and this information will be included, as appropriate. All surgery performed by podiatrists will be restricted to the foot that is distal to the tibiotalar or ankle joint, and the surgery will be under supervision of an orthopedic surgeon. If a podiatrist is stationed at an MTF where no orthopedic surgeon is available, the surgery will be limited to outpatient procedures in the clinic area only. Physician assistants may record admission history and physical examinations if these

findings have been carefully reviewed by the attending physician and if he or she so attests when countersigning the documents.
b. SF 509. SF 509 will describe chronologically the clinical course of the patient. SF 509 should reflect any change in condition and the results of treatment. SF 509 will be recorded by the person giving the treatment or making the observation. If integrated progress notes are approved for use by the Executive Committee of the MTF, pertinent data must be recorded on the SF 509 in chronological order by all disciplines involved in the care of the patient. Each entry must be clearly identified (for example, nurse's note), dated and signed. (See para 3-4c.)

(1) Progress notes by doctors. In addition to the information described in b above, doctors' progress notes, documented on SF 509, will analyze the patient's clinical course and outline the rationale for specific medical decisions. Doctors' progress notes (SF 509) begin with an admission note, continue with notes during hospitalization, and conclude with a final note on discharge, transfer, or death.

(a) The admission note will record briefly the clinical circumstances that brought the patient to the hospital, will summarize the proposed diagnostic workup, and will suggest the type of therapeutic management. For emergency patients, SF 558 will be put in the ITR and may be used as the admission note. (See para 5-14.) Associated consultations and diagnostic test reports will also be filed in the ITR. At the time of intrahospital transfer, a note will be written to summarize the course of the patient's illness and his or her treatment.

(b) For surgical patients, the admission note may serve as the preoperative note. In addition to giving the information in (a) above, these notes will justify the surgery and state the procedure proposed. If surgery scheduled within 24 hours of admission is not performed within 2 days, another preoperative note will be written by the surgeon. This note must again justify the surgery.

(c) The anesthetist's preanesthesia note that explains the choice of anesthesia for the proposed procedure will be recorded on OF 517. If there is not enough space on the back of OF 517, SF 507 (Clinical Record--Report on Continuation of SF) will be used for the remainder of the documentation. A postanesthetic note will be made after the patient has left the postanesthesia care unit or other recovery area. It will record the presence or absence of anesthesia-related complications, vital signs and level of consciousness, medications (including intravenous fluids) and blood and blood components.

(d) For the postoperative patient, progress notes (SF 509) will record the condition of the surgical wound, any indication of infection, and the removal of sutures and drains. The postanesthetic note may be recorded by a qualified, licensed independent practitioner or by the use of medical staff-approved criteria. Progress notes (SF 509) will also record examinations of chest and legs until the patient is ambulatory and afebrile, the use of casts or splints, and any other pertinent data.

(e) The final progress note (SF 509) will record the patient's general condition on discharge, the final diagnosis, and postdischarge care, including activity permitted, diet, medications, dressings, and the date and clinic for followup care.

(f) In hospital death cases, the final note (SF 509) will describe the terminal circumstances, findings, and final diagnosis. It should also state whether or not an autopsy was performed.

(g) The frequency of progress notes (SF 509) depends on the condition of the patient. They should be written every day or even every few hours during the acute phase of the illness. For surgical patients, there will be a daily note for at least the first 4 postoperative days. For convalescent patients and fracture patients with no complications, notes will not be needed as often as for patients receiving active treatment. In no case, however, will more than 7 days pass without a progress note.

(2) Progress notes by nurse anesthetists, nurse practitioners, clinical nurse specialists, and physician assistants. These personnel will record their progress notes on SF 509, as described in (1) above.

(3) Progress notes by nurses. Nurses' notes, documented on SF 510 (or SF 509 in those MTFs using integrated progress notes), will describe chronologically the nursing care given the patient. (See AR 40-407.)

(4) Dietetic progress notes. See AR 40-2, paragraph 9-13e.

(5) Physical and occupational therapy notes. Treatment given inpatients will be recorded on SF 509. When the entry is long and complex, SF 513 will be used, with reference made on SF 509. Each entry will be identified as a physical therapy or occupational therapy note; worksheets will not become a permanent part of the ITR.

(a) The therapist's first ITR entry should be the first evaluation of the patient, including the goals of the treatment program and the plan of care.

(b) Later entries should be periodic status reports, including the patient's response to treatment and any important changes in his or her condition or treatment program.

(c) The final summary note will be an evaluation of the therapy given, including the patient's progress, goal achievement, and any recommendations for postdischarge care.

(6) Social service notes. Social service personnel will record their notes on SF 509. These notes will include--

(a) Medicosocial study of the patient who needs social services.

(b) Social therapy and rehabilitation.

(c) Social service summary. (When the entry is long and complex, SF 513 will be used, with a reference made on SF 509. Each entry will be identified as a social work entry; social work case files will not become a part of the patient's ITR (file number 40-216f, social work individual cases).) (See AR 25-400-2 and table 2-1 of this regulation.)

(7) Psychology notes. Clinical psychologists may only admit patients to the MTF if a physician member of the active medical staff conducts the physical examination, assuming responsiblity for the care of a the patient's medical problems present at the time of admission, or which may arise during hospitalization which are outside the psychologist's lawful scope of practice. (See AR 40-48.) Psychology officers (area of concentration 68S) will record their notes on SF 509. The notes will include--

(a) Name, rank, branch, and professional title of the psychologist.

(b) Dates seen.

(c) Organizational unit where the consultation was performed (for example, (number) Division Psychologist or (name) Hospital Psychology Service).

(d) Reference to any consultation done on the patient and reported in more detail on SF 513.

(e) Any diagnostic or therapeutic services provided and any findings, diagnoses, or therapeutic outcomes.

(f) Any significant consultation contacts concerning the patient with other personnel, such as unit commanders, lawyers, teachers, family members, and so on.

(g) A summary at the completion of treatment.

(h) The psychologist's discharge order, which must be countersigned by the attending physician.

(i) A summary of extensive contacts and a complete reference made to SF 513 or other full reports. Clinical psychology case files will not become a part of the ITR (file number 40-216e, clinical psychology individual cases). (See AR 25-400-2 and table 2-1 of this regulation.)

c. SF 516. Reports for all cases involving surgery including operative or other invasive procedures such as cardiac catheterizations in the operating room or ambulatory surgery unit, even when performed under local anesthesia, will be dictated immediately after surgery and transcribed on SF 516, OF 275, or automated equivalents. (See para 3-3 for information on OF 275.) When the operative report is not placed in the record immediately after surgery (for example, there is a transcription or filing delay), an

operative progress note is entered in the medical record immediately after surgery. SF 516 will be filed in the ITR as soon as possible after surgery. All procedures performed anywhere other than the operating room or ambulatory surgery unit (for example, ward, clinic, or emergency room) will be described in the progress notes (SF 509). Procedural terminology on the SF 516 or SF 509, SF 502, and DA Form 3647 will be the same. SF 516 will include--

(1) The pre- and postoperative diagnosis.

(2) The name of the operation.

(3) A full description of the findings, both normal and abnormal, of all organs explored.

(4) A detailed account of the technique used and the tissue removed.

(5) Postoperative diagnosis.

(6) The condition of the patient at the end of the operation.

(7) Name of primary surgeon and any assistants.

d. SF 513. A consultant is a health-care provider who gives professional advice or services on request. A consultant must be well qualified in the field; qualifications are determined by the credentials committee. SF 513 will include the matters on which the requesting practitioner sought an opinion, consultant's review of the patient's medical record, and the consultant's findings and recommendations. Also see para 5-2b(2).

e. SF 502. The narrative summary will be dictated promptly at transfer-out or discharge of the patient and transcribed onto SF 502, OF 275, or automated equivalent. SF 502 should be concise (rarely more than one typewritten, single-spaced sheet). Diagnostic and procedural terminology on SF 502 or progress note (SF 509) ((2) below) and DA Form 3647 or CHCS automated cover sheet will be the same. (See paras 5-2, 5-19, 6-7, 8-7, 8-9, 8-14, and 8-17 for more information on SF 502.)

(1) SF 502 (in narrative form) will include--

(a) The reason for hospitalization, including a brief clinical statement of the chief complaint and history of the present illness.

(b) All significant findings.

(c) All procedures performed and treatment given, including patient's response, complications, and consultations. (Any prosthetic device that is permanently implanted in the body will be identified, including nomenclature of prosthesis, manufacturer, and serial numbers as provided.)

(d) The condition of the patient on transfer or discharge.

(e) The discharge instructions given to the patient or his or her family (that is, physical activity permitted, medication, diet, and followup care).

(f) All relevant diagnoses (including complications) made by the time of discharge or transfer.

(2) A progress note (SF 509) summarizing the case may be substituted for the narrative summary (SF 502) when--

(a) A transfer or discharge occurs within 48 hours after admission. (See para 8-17d.)

(b) An obstetrical case has a normal, uncomplicated delivery.

(c) A patient's problem is minor. (See para 8-17.)

(3) All hospital death cases require a narrative summary.

f. SF 503. The pathologist's provisional anatomic diagnoses will be entered in the ITR within 72 hours; the complete protocol will be recorded on SF 503 within 60 days. SF 503 will include--

(1) Gross anatomical findings and toxicological analyses.

(2) Provisional pathologic diagnoses.

(3) Final diagnoses based on the definitive microscopic findings and toxicological analyses.

8-10.1. Nursing process documentation

a. DA Form 3888 (Medical Record--Nursing History and Assessment).

(1) Purpose. DA Form 3888 documents a baseline nursing history and assessment on each patient requiring nursing care. It may serve as the admission nursing note.

(2) General. The nursing history and assessment will be completed within the time specified in unit specific policy. The RN may use multiple modalities to collect patient data from which a plan of care is developed. Regardless of what data is collected, and by whom, the RN is responsible for its validity and reliability. Although all nursing personnel may participate in data collection, the assessment must be completed and documented by the RN. Overprints that serve as guides for the nursing history and

assessment may be printed on the forms in accordance with the appropriate local or command policy.

(3) Preparation. Enter all patient data as indicated on the forms.

(4) Content. Data entered on DA Form 3888 represents baseline health status information used by the nurse to plan care. The information may be obtained from the patient, other informed persons, and/or the patient's records.

(a) The front portion of the form, containing a brief series of questions, provides a guideline for the interview.

1 Date and time of admission with admitting diagnosis as specified by the physician, are recorded in the provided space.

2 Response by the patient to the interview questions is recorded next to the questions in the area provided.

3 Spaces are provided for the recording of information to assist in contacting the next of kin, or in their absence, another person designated as a point of contact for concerns arising as a result of the hospital episode (for example, support person, company commander, first sergeant, etc.).

4 The person collecting the data is to sign his or her name, rank, and title and specify the informant from whom the data was obtained by name and relationship (for example, patient, Mrs. Jones or aunt, Mrs. Allen).

5 A space is provided for the noting of the disposition of articles brought to the hospital. Initialing by the interviewer attests to where such items were consigned. It does not mean the interviewer was the one who actually placed the article(s) in the designated area.

(b) The reverse side of DA Form 3888 provides spaces for recording admission vital signs and for completing the nursing history and nursing assessment.

1 Categories of assessment, with guidelines, are provided at the bottom of the page for assistance in making the nursing assessment. Data on the biophysical parameters for the listed items should be collected as appropriate for planning care.

2 The date and time is recorded on the DA Form 3888 with the signature of the RN who completed the nursing assessment. If the DA Form 3888 is completed at the time of admission, an admission note is not required in the nursing notes. An entry must be made in the nursing notes to refer to the DA Form 3888 for the admission note.

b. DA Form 3888-2 (Medical Record--Nursing Care Plan).

(1) Purpose. DA Form 3888-2 is used to document identified nursing care problems with patient focused goals derived from the problems and discharge considerations to include patient and family educational needs. Although all persons involved in the patient's care will contribute to the development of the care plan, the RN is responsible for its preparation. It is used by all nursing personnel caring for the patient. The nursing care plan is a permanent part of the patient's ITR.

(2) Preparation. Enter all patient identification data as indicated on the form.

(3) Content. The nursing care plan will reflect current nursing standards and measures which will facilitate the prescribed medical care and restore, maintain, and promote the patient's well being. It is used in conjunction with DA Form 4677 and DA Form 4678 that list the nursing actions and other prescribed orders related to implementing the doctor's orders and to achieving the specified goals.

(a) Record the date nursing diagnoses and/or patient problems are identified, the initials of the responsible RN, and the sequence number of the problem in the appropriate columns.

(b) The primary problems or nursing diagnoses to be addressed during this hospitalization will be listed in the appropriate column. Nursing diagnoses describe the patient's actual or potential health problems. As patient problems (or nursing diagnoses) are identified, they are recorded in the appropriate column and numbered in sequence. The RN is responsible for review and revision of the problems/nursing diagnoses to reflect the changing needs of the patient.For each identified problem and/or nursing diagnosis, a nursing order(s) must be written on DA Form 4677 and/or DA Form 4678.

(c) Expected outcomes (goals) are to be stated as patient outcomes. These should be mutually set with the patient and/or family. The goals will be realistic, measurable, and consistent with the multidisciplinary plan of care. When a problem no longer exists or the goal was accomplished, the date the goal was accomplished or revised will be entered in the Date Accomplished column. Corresponding nursing orders will be discontinued and, if indicated, new orders will be written.

(d) In those instances when there are no individual patient care problems identified on admission, the RN will document this on the care plan. Each patient's status will be reassessed as established in unit specific policy.

(e) Discharge planning begins at admission with the assessment by the RN on DA Form 3888. Note the discharge considerations identified at admission and throughout hospitalization in the space provided on DA Form 3888-2.

c. SF 510 (Clinical Record--Nursing Notes).

(1) General. Nursing notes provide a chronological record of the nursing care provided, the patient's status, and/or responses to nursing interventions. The documentation should reflect change in condition and results of treatment. The SF 510 is not required when nursing notes are integrated on the SF 509.

(2) Preparation. Enter all patient identification data as indicated on the form. Each entry by nursing personnel will be preceded with the date and time of the entry. If applicable, reference the patient problem/nursing diagnosis being addressed. Each entry will be appropriately signed.

(3) Admission note. If the DA Form 3888 is completed at the time of admission, an admission note does not need to be recorded in the nursing notes. If DA Form 3888 was not completed at the time of admission, an admission nursing note must be recorded that includes the date, time, manner of admission, reported known allergies and a brief but clear description of the patient's status.

(4) Discharge note. If the DA Form 3888-3 has been completed prior to or at the time of discharge, a discharge note does not need to be recorded in the nursing notes. A notation will be made in the nursing notes "Patient discharged. See DA Form 3888-3." In the absence of a discharge summary form, an entry must be recorded in the nursing notes which includes the date, time, manner of discharge, patient status, a concise summary of the discharge plan, the patient's progress toward achieving nursing goals, and the name of the person or agency accepting responsibility for the patient.

(5) Content. Documentation of nursing care is pertinent, concise, and reflects patient status. Nursing interventions and patient status are noted including the patient's response to medical orders, the patient's response to the implementation of the individualized nursing care plan, and the applicable nursing standards of care.

(a) Format of notations. Format is determined by local policy. However, components of the nursing process; that is, assessment, planning, implementation and evaluation, will be evident in the notes.

1 Each notation will be preceded with the date and time of the entry. The specific time the note is being written should be indicated. Block charting (for example, 0700-1500) is not authorized.

2 All notes will be appropriately signed. As necessary a line will be drawn to eliminate any unused space between the entry and the signature.

(b) Delayed entries. An entry may be made out of chronological order by noting the date and time of the entry followed by a statement that this recording is out of sequence.

(6) Frequency of charting. The minimum charting frequency of the patient's status for category 4, 5 and 6 patient's is one entry per shift, category 2 and 3 patients

once a day and category 1 patients once a week. More frequent charting will be dictated by local policy, changes in the patient's status, the patient's response to treatment, incidental occurences and the judgement of the RN responsible for the care of the patient.

(a) If no notation appears, it indicates that there has been no significant change in the patient's status. The patient received care as ordered; no abnormal observations were made and no unusual activities or incidents were noted.

(b) Any "STAT" procedures and medications which were necessitated by a change in the patient's condition, must be documented in the nursing notes.

(c) Documentation of patient transfer to and from the following areas is mandatory: OR, recovery room, treatment off the MTF premises and to another nursing unit.

(7) Documentation. Documentation by nursing personnel other than the RN does not absolve the RN (that is, clinical head nurse, charge nurse, team leader, etc.) of the responsibility for professional supervision to include the review of both the appropriateness of the nursing care delivered and the documentation of that care.

(8) Student charting. The policy for student charting will be determined by the Chief Nurse at the MTF and the faculty representative of the nursing program.

d. DA Form 3888-3 (Medical Record--Nursing Discharge Summary).

(1) Purpose. DA Form 3888-3 is used to facilitate summarizing the patient's plan of care at the time of discharge from the MTF. It is a three-copy carbonless form, with the second page being the patient's copy of the discharge instructions. It can be used in lieu of a discharge nursing note. An entry will be made in the nursing notes to refer to the DA Form 3888-3.

(2) Preparation. DA Form 3888-3 is a three-copy carbonless form. The original copy becomes part of the patient's ITR (filed in DA Form 3444 series folder); the second copy is reviewed with the patient and retained by the patient or family, and the third copy is placed in the HR or OTR (filed in DA Form 3444 series folder).

(a) Entries can be made by all nursing personnel. The RN is responsible for ensuring the accuracy and completeness of the entries, and for reviewing the instructions with the patient or significant other person prior to discharge.

(b) All patient identification information is to be entered in the space provided on the form.

(3) Content. Information on this form will be pertinent, factual, and written in terms understood by the patient and family.

(a) Complete the form as specified by each section of the summary.

(b) The writer's initials, followed by "yes" or "no," as appropriate, are recorded in all blocks related to patient understanding of instructions.

(c) "N/A" is placed in those spaces not applicable, or where notation is unnecessary.

8-11. Countersignatures

a. The following ITR reports and entries will be countersigned by the supervising physician or, when appropriate, by a qualified oral and maxillofacial surgeon:

(1) Histories and physical examinations performed by someone other than the senior resident, staff physician, qualified oral and maxillofacial surgeon, or certified midwife.

(2) Operation reports (SF 516) written or dictated by someone other than the surgeon.

(3) Narrative summaries (SF 502) written or dictated by someone other than the attending physician, dentist, podiatrist, or midwife in charge of the case.

(4) Doctors' verbal and telephone orders (DA Form 4256). (These orders will be countersigned by the prescribing physician.)

b. Progress notes (SFs 509) do not require the countersignature of the supervising physician or nurse.

c. When personnel in approved graduate medical education programs are involved in patient care, the care provided will be documented on SF 509 and SF 510, as appropriate. Sufficient evidence will be documented in the medical record to substantiate active participation in and supervision of the patient's care by the responsible program preceptor. Documentation of histories and physicals (SF 504, SF 505, and SF 506) and doctors' orders (DA Form 4256), when an integral part of the program, will be countersigned by the preceptor physician or, when appropriate, by a qualified oral and maxillofacial surgeon.